Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KILLEEN INJURY CLINIC INC
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1537-01

MFDR Date Received
JANUARY 18, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is our position that Chartis Inurance [sic] has established an unfair and unreasonable time frame in paying for the services that paid/processed incorrectly."

Requestor's Position Summary from Table of Disputed Services: "CPT code 97545 is for the initial 2 hours only 1 hour paid." "CPT code 97546 is for 5.5 units only 5 units paid."

Amount in Dispute: $1,656.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2010 through July 9, 2010	Work Hardening Program – CPT Code 97545-WHCA (2 hours per day for 19 days)	$85.25/day x 19 = $1,619.75	$1,619.75
June 8, 2010	Work Hardening Program – CPT Code 97545-WHCA (2 hours per day)	$16.15	$16.15
June 8, 2010	Work Hardening Program – CPT Code 97546-WHCA)	$38.50	$38.50
TOTAL		$1,656.80	$1,656.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific*

Services, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - P303-This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - Z003-Any reduction is in accordance with the FOCUS-Aetna Workers Comp Access LLC contract.
   - M463-Payment has met the maximum allowance for multiple services.
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - Z562-If a provider's charge is greater than the MAP. The provider may not bill the patient or employer for the difference.
   - Z656-Any request for reconsideration of this worker's compensation payment should be accompanied by a copy of this explanation of review.

Issues

1. Does the submitted documentation support a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes "P303 and Z003." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. On the disputed dates of service the requestor billed for a work hardening program using CPT codes 97545-WH-CA and 97546-WH-CA.

   28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   The requestor appended modifier CA to designate that the program was CARF Accredited.

   28 Texas Administrative Code §134.204(h)(3) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

   The requestor states in the position summary that "CPT code 97545 is for the initial 2 hours only 1 hour paid." "CPT code 97546 is for 5.5 units only 5 units paid."

   The Division finds that the requestor billed the work hardening program and is due the following:

   - CPT code 97545-WH-CA for two (2) hours on twenty (20) disputed dates of service is $64.00 per hour x 2 hours = $128.00 per day. $128.00 times 20 disputed dates is $2,560.00. The carrier paid $917.70. Therefore, the difference between the MAR and amount paid is $1,642.30. On June 8, 2010, the requestor is seeking a $6.40 reduction from the MAR. Therefore, $1,642.30 minus $6.40 = $1,635.90. As a result, this amount is recommended for reimbursement.
   - CPT Code 97546-WH-CA for five and a half (5.5) hours billed on June 8, 2010 is $64.00 per hour x 5.5 hours = $352.00. The respondent paid $313.50. The difference between the MAR and amount paid is $38.50. As a result, this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,656.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,656.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

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Authorized Signature

		8/8/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.